STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E242	A. BUILDING _____ B. WING _____	C 09/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOSPITAL ONAGA LTCU	206 GRAND AVE ST MARYS, KS 66536

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation # 90324	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 37 residents. The sample included 4 residents. Based upon record review, observation and interview the facility failed to provide adequate supervision to prevent falls for 1 (#1) a closed record review of 4 sampled residents who fell and sustained a fracture. Findings included: - Resident's #1's electronic medical record revealed the resident had a diagnosis of dementia (- progressive mental disorder characterized by failing memory, confusion), fracture of the lumbosacral (pertaining to the lumbar and sacral region) spine and pelvis, and osteoarthrosis (chronic noninflammatory bone disease). The resident's quarterly Minimum Data Set (MDS) dated 6/7/15 identified the resident scored 3 (severely impaired cognition) on the Brief	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Interview for Mental Status (BIMS) and displayed verbal behaviors 1 to 3 days during the 7 day assessment period. The resident required extensive staff assistance with bed mobility, transfers, walking in the room/corridor, toilet use, personal hygiene and required limited staff assistance with dressing. The resident was not steady and was only able to stabilize himself/herself with staff assistance when moving from a seated to a standing position, walking, surface to surface transfers, and moving on/off the toilet. The resident had an impairment on one side of his/her upper extremity and on both sides of his/her lower extremity, and had 1 or more non- injury falls and 1 injury major fall since the prior assessment.

The resident's Cognitive Loss Care Area Assessment (CAA) dated 1/11/15 documented the resident was admitted last year with diagnoses of dementia, coronary artery disease, congestive heart failure, depression. His BIMS score on admission was 10 (moderately impaired cognition) and three months later it was a four (severely impaired cognition) and the resident's family states he/she was more confused and did not always recognize them. At night the resident thought he/she was still working on the ranch.

The resident's Fall CAA dated dated 1/11/15 documented the resident fell in his/her room on 11/27/14, 12/04/14, 12/17/14 at night each time and with each fall the resident was trying to go to the bathroom. The resident was not on a 2 hour toileting schedule at night. The resident required a walker and staff support to ambulate due to balance problems and poor safety awareness and was on a nursing restorative program to maintain function.

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The resident's Fall Assessments dated 3/17/15 and 6/16/15 identified the resident was at high risk for falling.

The resident's care plan revised on 8/11/15 included the resident was at high risk for falls related to an unawareness of safety needs, use of psychotropic medication, gait/balance problems, incontinence and actual falls. Since 1/11/15 the resident utilized a chair/bed alarm at all times, staff ensure the device was in place and working. Staff anticipated and met the resident's needs and the resident did not use the call light. The resident fell at night and was on a two hour toileting schedule, staff kept the resident's room and hallways clutter free and frequently observed the resident.

A nursing note (NN) dated 6/13/15 and timed 2:24 A.M. documented the resident bed alarm sounded. The resident stood up and urinated on the floor. The resident had on "grippy socks", slipped on urine and fell into his/her bed.

A NN dated 6/16/15 and timed 12:29 P.M. documented the resident's alarm sounded and as staff came around the corner the resident stood by the wall. The resident stood and walked unassisted without staff or his/her walker. The staff was unable to reach the resident before he/she fell on his/her buttocks and then over to his/her right side on his/her elbow keeping his/her head forward. The resident complained of right arm, elbow, wrist, lower back and hip pain and the facility received a physician's order to transfer the resident to a local emergency room for assessment.

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A NN dated 8/9/15 and timed 2:05 P.M. documented the resident got out of a recliner in the living room without assistance and fell when he/she reached the dining room and tile floor. The resident had on shoes that were appropriately tied and the floor was dry. The event happened at shift change with the nursing staff at the nurses station finishing report. The resident laid on his/her right side, his/her right arm was behind his/her back and the resident leaned forward a bit. The resident moaned and groaned as in pain, complained of pain in his/her right shoulder and right hip. At 2:15 P.M. the facility received a physician's order to transfer the resident to the emergency room and to obtain x-rays. At 2:55 P.M. the facility transferred the resident to the emergency department for x-rays.

A Radiology report dated 8/9/15 documented the reason for the exam was the resident fell. The impression was the resident had an acute fracture of the right acetabulum ((the socket of the hipbone, into which the head of the femur (thigh bone) which also involved the right superior and inferior pubic ramus (group of bones that make up a portion of the pelvic bone). There was a medial displacement of the femur (thigh bone) and protrusion acetabuli.

A NN dated 8/9/15 timed 7:00 P.M. documented the resident was transferred to a hospital for outpatient observation due to having 2 falls in the last 6 weeks that required x-rays.

A NN dated 8/10/15 and timed 4:40 P.M. documented the resident arrived back to the facility.

A NN dated 8/11/15 timed 11:01 A.M.

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documented the facility received the emergency room progress note. The note include the ER progress note read the resident was brought to the emergency room because the resident had an unwitnessed fall. The resident was cognitively impaired and complained of right hip and shoulder pain. The note included the resident had a pelvic fracture into the acetabulum(the socket of the hipbone, into which the head of the femur (thigh bone) fits) and was bedrest and non-weight bearing for now. The physician doubted the resident was a surgical candidate due to the resident's age.
Review of facility's investigation regarding the incident included that on 8/9/15 at approximately 2:04 P.M. the resident sat in a recliner in the living area, and rose form his/her chair. A pressure alarm was present in the seat of the recliner but the alarm did not sound. The pressure alarm was not turned on. The resident walked, unassisted approximately 8 feet. Staff was present in the dining area however the resident was not visualized when he/she rose. The resident wore shoes with non-skid soles and were appropriately fastened. As a staff entered the area, he/she heard a noise that was later identified as the resident demonstrated loss of balance and fell to the floor. The facility counseled the staff involved in the incident, and assigned mandatory education classes preventing falls and trauma and preventing high risk occurrences on or before the staff's next assigned shift.

On 9/9/15 at 1:32 P.M. direct care staff H stated the resident was at risk for falls. He/she stated the resident utilized a bed and chair alarm at all times. Direct care staff H stated he/she was on duty when the resident fell but he/she did not witness the fall. He/she stated it was his/her

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understanding an alarm was in the chair but was not turned on. He/she stated prior to the fall the resident sat in an electric lift chair. Direct care staff H identified the recliner where the resident sat at the time of the fall. Direct care staff H stated the resident often times sat in the electric lift chair and staff did not ensure the electric lift chair remote was not within the resident's reach. He/she stated the chair was always plugged in. Observation revealed the recliner was an electric lift chair. Further observation revealed no resident sat in the recliner, the remote to the recliner was on the arm of the chair and the chair was plugged in.

On 9/9/15 at 2:13 P.M. licensed nurse F stated he/she worked the evening shift on the date of the incident. He/she stated the resident sat in a recliner with the foot rest up prior to the fall. Licensed nurse F stated after the fall the footrest of the recliner was down and he/she assumed the resident had lowered the footrest. He/she stated the remote was always accessible to residents and residents could figure out how to use the remote. Licensed nurse F stated he/she heard another yell, he/she went to see what was going on and he/she heard a noise like someone had hit the floor and he/she observed the resident on the floor. He/she stated there was an alarm pad in the recliner where the resident sat but it did not alarm. Licensed nurse F stated the resident was to utilize an alarm at all times. He/she identified the recliner where the resident sat. Observation revealed it was the electric lift chair identified by direct care staff H.
On 9/9/15 at 3:30 P.M. administrative nursing staff D stated on the date of the incident the resident sat in a recliner in the living room. He/she stated there was an alarm pad in the

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recliner but it did not alarm. He/she stated the staff that placed the resident in the recliner did not turn the alarm on; therefore it did not alarm.
Administrative nursing staff D stated the facility did not ensure residents with cognitive impairment were safe to use an electric lift chair with an accessible remote prior to placing residents in electric lift chairs. He/she stated if the footrest of the recliner was in an up position and if the remote was not accessible the chair would be a restraint which is why the facility did not ensure residents could safely use the electric lift chair.
The facility's Fall Policy and Procedure dated 7/30/2014 included appropriate fall risk prevention interventions would be initiated on admission based on the residents fall risk assessment.
The facility failed to provide adequate supervision, failed to ensure the alarm was on as planned and failed to ensure the resident's safety was not compromised prior to placing this severely cognitively impaired resident in an electric lift chair with access to the remote for this resident with a history of falls who fell and sustained a fracture.